

# Facts About Aid in Dying and Access to Medical

## Aid in Dying Act Benefits Californians with lower incomes or without health insurance

Aid in Dying expands end of life choices and improves end of life care for ALL terminally ill patients, including those who lack health insurance or access to medical care. Making this choice legal in California gives every Californian, rich or poor, access to the comfort and hope that comes with having a choice.

Currently only the very wealthy can travel to Switzerland or Holland, where aid in dying is legal, if their suffering becomes unbearable.

## Leaders of California's low income and minority communities Support Compassionate Choices for the Terminally Ill



"Currently, upper income patients have more end of life choices. California's low-income terminal patients should not have their options limited just because of their economic status. They should be given equal opportunity to choose

what is personally best for them. This bill will allow those of modest means the same access to end of life choices as the well-off."

**Rev. Ignacio Castuera, St. John's United Methodist Church, Watts**

"Persons without health insurance would benefit from these additional choices. All of my patients are on Medical. They deserve the same end of life choices that the well-off can access."

**Richard Ikeda, MD, Founder, Health For All Community Clinics, Sacramento**



"The Oregon experience shows no adverse impact on the poor or uninsured. All but two of the terminal



patients who died using Oregon's end of life choices were insured. The two had full access to excellent end of life care."

**Barbara Coombs Lee, Compassion and Choices, Oregon**

## FAQ about AID IN DYING

### Wouldn't people without health insurance be more likely to be pressured to choose assisted dying under this law?

No. People without health insurance are eligible for hospice care. There is no financial incentive for hospice to shorten a length of stay, as they are paid a daily rate.

The current underground, covert, illegal system is much more dangerous for poor people. An open system with state oversight, checks and balances and numerous safeguards, is the best way to protect vulnerable people. Studies show legalization reduces the numbers of hastened deaths and imposes safeguards that make it safe.<sup>1</sup>

### Could HMOs reduce medical costs by encouraging terminal patients to hasten their deaths rather than seek treatment?

Studies show that HMOs have no financial incentive to pressure terminal patients to hasten deaths because there are no cost savings.<sup>2</sup>

It is well documented that the legal choice to hasten an imminent death is not related to finances.<sup>3</sup> End of life choices are relevant only AFTER all curative or other

<sup>1</sup> Ezekiel Emanuel and Margaret Battin, "What are the Potential Cost savings from Legalizing Physician-Assisted Suicide?" The New England Journal of Medicine, July 16, 1998.

<sup>2</sup> Linda Ganzini, "Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide." New Eng J of Med, August 22, 2002. OR Dept of Human services, "Seventh Annual Report on Oregon's Death with Dignity Act."

<sup>3</sup> Ganzini & Dobcha, "Clarifying Distinctions Between Contemplating and Completing Physician-assisted Suicide," Journal of Clinical Ethics, Summer 2004. (Showing illegal aid in dying occurs in 1 in 250 deaths in states where it is illegal and 1 in 1000 in Oregon.)

treatments have been tried. Aid in dying comes within the hospice setting, which is paid by Medicare, not HMOs. When a patient enters hospice, an HMO turns the care over to Medicare to reimburse the hospice. The HMO is essentially out of the finances. HMOs play a small role in that setting, and have no financial incentive to influence patient choices.

Hospice use has increased in Oregon since aid in dying became an option. In Oregon, hospice care averages 85 days, compared to California's 19-day average.

The safeguards in the bill ensure only the patient can make a request and the patient must control the process from beginning to end. Unlike today, the bill requires physicians to discuss ALL end of life options with patients, including comfort care, hospice care and pain control. This disclosure is required to be in writing. Patients must take the medication themselves.

### **Do low income and minority Californians support aid in dying?**

A majority of every ethnic group in California support aid in dying. Majorities of every income group also support providing the terminally ill with compassionate choices.

### **Do most people regardless of income support this choice?**

Yes: regardless of income, Californians support this choice by clear and commanding majorities across all demographics. The opponents base their opposition on fears that individuals who are impoverished or who are ethnic minorities will somehow be tricked into choosing this option at the end of their life. Eight years of reporting in Oregon by the neutral Department of Health Services show that there is no basis for these fears. Stories by opponents prey on the fears of those who have been underserved by an imperfect healthcare delivery system. The aid in dying process will only be the choice of a tiny percentage of dying patients. Nothing in the bill requires dying patients to choose this option or to even discuss it with their doctor. It is one of the few medical procedures where a patient controls the process from beginning to end.

### **How many people without the ability to receive excellent end of life care have died invoking Oregon's law?**

Not a single one.

### **But aren't poor or minority patients more likely to choose assisted dying because they can't afford care?**

People with low incomes or members of racial minority groups value life and power and freedom as much, maybe more, than everyone else. Data from Oregon shows clearly that individuals with low incomes, like most terminally ill patients, rarely choose this option at the end of their lives, but derive comfort from having the choice. Medical research also indicates that minority patients and their families tend to engage in futile medical therapies at the end of their lives, more often than others. In any case, only those diagnosed with less than six months to live are eligible to make this choice.

### **Won't greedy HMO's and uncaring doctors use this as a way to make profits, by having poor or vulnerable patients choose assisted dying rather than receive expensive care?**

HMOs and doctors would have no power whatsoever to do anything except respect their patients' wishes. The choice is entirely the individual's. The safeguards built into Aid In Dying give patients sole control over their end of life choices.

**Aid in Dying, Dignity, Freedom, Power,  
Autonomy for Everyone**

## ***CMA PHYSICIANS*** **for Compassionate Choices**

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